HOUSE REPUBLICAN CONFERENCE
CHAIRMAN MIKE PENCE

Question and Answer: International Lessons of Government Control and Rationing of Health Care

March 20, 2009

The Republican Conference has compiled background on the implications of comparative effectiveness research and the federal government's role in rationing health care in light of recent experiences under a government-run health system overseas.

What is comparative effectiveness research?

Broadly speaking, comparative effectiveness research evaluates the relative merits of various medical treatments, in the hopes of arriving at a set of best practices for treatment of a condition. Of critical importance is the distinction between *clinical effectiveness*—i.e., which treatments work best irrespective of cost—and *cost effectiveness*—where the most effective treatments could be deemed inappropriate because their costs outweigh the perceived benefits in the government's eyes.

Have other countries' use of effectiveness research caused delays in treatment?

Yes. One of the examples cited as a model for American comparative effectiveness research is Britain's National Institute for Clinical Excellence (NICE), established in 1999 as part of the National Health Service (NHS). The first decade of experience with NICE has exposed difficulties in the comparative effectiveness model, including delays in the evaluation of treatments. A June 2007 Government report found that "it has sometimes taken too long for NICE appraisal guidance to be made available on newly licensed drugs," resulting in years-long delays for patients to access drugs already approved safe for use but not evaluated on cost-effectiveness grounds.

Does government rationing of health care affect physicians' practice of medicine?

Yes. In Britain, a recent study found that one quarter of cancer specialists are keeping their patients "in the dark" about available treatment options—in order to avoid upsetting those patients when they find out the NHS will not pay for their treatments. Some Members may be concerned at the implications of this form of "self-censorship" significantly altering the doctor-patient relationship, particularly when it results in patients not receiving access to potentially effective care.

Are individuals permitted to pay for unapproved treatments using their own funds?

Not always. Until recently, British patients who wished to obtain treatments not approved by NICE could do so—but only if they agreed to pay all follow-up costs and renounce their right to follow-up NHS care. The effective prohibition on patients receiving NHS care from using their own money to fund treatments deemed not cost-effective sparked a massive public outcry. Stakeholders viewed the prohibition as "despicable," "appalling," "uncivilised," "spiteful," "cruel," "abhorrent," "perverse," "inhuman," and "unjust"—even though most stakeholders agreed that some form of rationing within the NHS was inevitable. As a result, a November 2008 report reversed the ban on so-called top-up payments, allowing patients to pay for drug therapies not deemed cost-effective by NICE while retaining access to NHS care.

If patients in the American system may supplement their Medicare or other government coverage with private funds, Members may be concerned that this "two-tier" health system would have a disproportionate impact on poorer individuals, who will not have the resources to purchase supplemental care. Conversely, if "top-up" payments are prohibited, Members may strongly oppose an effective ban on patients using their own money to obtain care.

Has comparative effectiveness research generated significant budgetary savings?

Only to the extent that government entities are willing to ration health care based on the research. A December 2007 CBO report admits that such decisions "could be difficult and controversial," and further notes studies suggesting that "patients who might benefit from more-expensive treatments might be made worse off" as a result of changes in reimbursement patterns.

The British experience suggests that political considerations may mitigate any perceived savings. For instance, in August 2008, NICE adopted a policy of refusing to pay for four kidney cancer drugs, even though the pharmaceuticals made "significant gains" in survival times, because NICE did not believe the drugs were cost-effective. However, public outrage culminated in a policy shift, whereby NICE in January 2009 relaxed its cost-effectiveness criteria for patients in their final months of life on compassionate grounds. Members may believe that such political pressure in the United Kingdom—a country with a consensus supporting government-rationed care—should serve as a cautionary tale to those who believe that comparative effectiveness research provides a painless solution to slowing the growth of health care costs.

Do many Democrats believe that comparative effectiveness research should be used to ration health care?

Yes. Democrat press releases trumpeting $1.1 billion in "stimulus" funding for comparative effectiveness research cited CBO data that comparative effectiveness could generate billions in budgetary savings. In addition, a draft Committee report describing the research funding stated that "more expensive [treatments] will no longer be prescribed" as a result of the "stimulus" funding.

In addition, the liberal Commonwealth Fund recently released its own report proposing $634 billion in savings over ten years from comparative effectiveness research and subsequent rationing of care. The report asserts that "merely making information available" about the relative merits of treatments "is unlikely to produce" outcomes yielding sufficient savings—and therefore recommends that the new comparative effectiveness center help "***to create financial incentives for patients and physicians to avoid high-cost treatments***." Among other recommendations, the Commonwealth study presumes that the government "would specify circumstances where coverage of procedures and services is restricted on the basis of evidence on the potential benefit to patients" and double co-payments "for people who agree to receive higher cost procedures in cases where a less costly procedure is at least as effective"—which could result in patients who would benefit from more-costly treatments not having access to effective care based on government bureaucrats' decisions.

For further information on this issue see:

- *CBO Report on an Expanded Federal Role in Comparative Effectiveness Research*

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